REPUBLIC OF TRINIDAD AND TOBAGO

IN THE COURT OF APPEAL

Civil Appeal No. P 211 of 2012
Claim No. CV2008-00912

Between

DR. KONG SHIEK ACHONG LOW

Appellant

And

BRIAN LEZAMA
(Administrator of the Estate of Karen Lezama, Deceased)

Respondent

PANEL: **N. BEREAUX, J.A.**
R. NARINE, J.A.
M. MOHAMMED, J.A.

APPEARANCES: **I. Benjamin and A. Bullock for the appellant**
S. Marcus SC and P. Dindyal for the respondent

DATE DELIVERED: 27 March 2018

JUDGMENT

Delivered by Bereaux, J.A.

Introduction

[1] This is an appeal from the decision of the High Court, given on 26th July, 2012 by which the appellant, Dr. Kong Shiek Achong Low (the appellant or Dr. Achong Low), a specialist obstetrician/gynaecologist, was found liable in negligence for the death of Mrs. Karen Lezama (Karen or Mrs. Lezama). Mrs. Lezama died on 6th April, 2003 while under the care of the appellant after giving birth to a stillborn baby boy. She was a mother of three children. Her previous three deliveries had been uneventful. Her death occurred at Stanley's Clinic (Stanley's) located at 1 Rapsey Street, St. Clair, Port-of-Spain. The respondent, Brian Lezama, (Brian or Mr. Lezama) is her widower and father of the three surviving children and of the stillborn child. He is the administrator of Karen's estate. He brought these claims under the Supreme Court of Judicature Act Ch. 4:01 and under the Compensation for Injuries Act Ch. 8:05. The appellant was the second named defendant in the trial. Proceedings against Dr. Leola Weithers, the first named defendant, were discontinued. The judge granted judgment for the respondent ordering that the appellant pay the respondent's costs to be quantified by the master on a date to be fixed. The respondent has filed a counter-notice challenging the costs order.

[2] Stanley's was a medical facility which specialized as a maternity centre. It had no operating theatre or intensive care unit. Neither did it carry any storage facility for blood units. Any blood transfusion at the facility had to be specially arranged beforehand and was based on the anticipation of more than the usual haemorrhaging associated with childbirth. Such arrangements were made if, because of the patient's medical history, blood was required during or after delivery.

[3] Dr. Achong Low, in the registration of death entry, recorded that Mrs. Lezama died of disseminated intravascular coagulopathy (DIC) and post-partum haemorrhage (PPH). He also listed *"stillbirth"*. DIC is described as a rare condition which may cause excessive clotting or bleeding throughout the body. The haemorrhaging began almost immediately after delivery of the baby. The baby was delivered at 4:53 p.m. By 5:15 p.m. Karen had lost consciousness. Dr. Achong Low estimated the loss of blood at that stage to be about eight hundred (800) cc which was more than the normal blood loss expected during delivery. The blood he said *"was pale pink and watery and not bright red and was not clotting"*. Dr. Achong Low said that at that stage he diagnosed Mrs. Lezama as having an amniotic fluid embolus which one medical expert (Dr. Rawle Jibodh) in this case described as having a mortality rate as high as ninety percent (90%). All the experts in this case agree that although AFE is rare, the mortality rate is quite high.

[4] It is accepted that the appellant, a medical practitioner, would not be held negligent if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular field. See **Deonarine v. Ramlal, Civil Appeal No. 28 of 2003** and **South West Regional Health Authority v. Harrilal, Civil Appeal No. 60 of 2008**. These two authorities apply the decision in **Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582**. The ultimate question to be answered in this case is whether the appellant's treatment of Mrs. Lezama met that standard and, if it did not, whether his failure so to treat resulted in Mrs. Lezama's death. The latter issue is a question of fact. The onus is on the person alleging negligence, in this case, the respondent.

The claim

[5] According to the statement of claim, Mrs. Lezama, then in late pregnancy, was admitted to Stanley's on April 2nd, 2003. She was diagnosed as being in

"early labour". Bed rest was ordered. She was discharged on April 3rd, 2003. On this day Dr. Leola Weithers was Mrs. Lezama's regular obstetrician/gynaecologist. Dr. Weithers subsequently asked Dr. Achong Low to assist in Mrs. Lezama's care because she had to leave the country. On April 6th 2003, Mrs. Lezama was re-admitted to Stanley's at about 8:30 a.m. She was at this point under the care of Dr. Achong Low. She had complained of no foetal movements from the day before. A drip was administered to induce labour. The stillborn child was delivered at 4:53 p.m. Almost immediately afterwards Mrs. Lezama began to haemorrhage profusely. She died on 6th April, 2003 at 10:10 pm from shock due to DIC and PPH.

[6] In addition to Mr. Lezama's and the appellant's evidence, Dr. Petronella Manning-Alleyne, Dr. Mary Singh-Bhola, Professor Hubert Daisley, Dr. Harold Chang, Dr. Hemant Persad and Dr. Rawle Jibodh gave evidence. Dr. Singh-Bhola and Professor Hubert Daisley gave expert evidence on Brian's behalf. Dr. Rawle Jibodh testified on behalf of the appellant and Dr. Hemant Persad was called by Dr. Weithers but was cross-examined on his witness statement by Mr. Marcus SC after reliance was placed on it by Mr. Young, then counsel for the appellant. Dr. Manning-Alleyne is a paediatrician and was a friend of Karen. Dr. Manning-Alleyne was in the delivery room when the baby was delivered. She also testified on Mr. Lezama's behalf. She did not give expert evidence but gave an eye-witness account of the chain of events as they occurred, with a medical eye. She readily admitted that obstetrics/gynaecology was not her specialty. She was there merely to counsel Mrs. Lezama because the baby had died. Dr. Chang, an anaesthetist, gave evidence on behalf of Mr. Lezama. He too was not called as an expert per se but gave an eye-witness account of what occurred while he was there. Additionally, Ms. Margaret D'Hereaux, mother of Mrs. Lezama, testified on behalf of Mr. Lezama. Three other witnesses gave witness statements. Their evidence went to damages but it was eventually agreed that liability alone would be considered. Their evidence is therefore irrelevant to this appeal.

[7] At paragraphs 10 and 11 of the Statement of Claim (the matter started under the Rules of the Supreme Court 1975) Mr. Lezama claimed that:

> ***10. The Defendants who treated and attended to the deceased at all material times and who knew or ought reasonably to have known that the deceased was a "gestational diabetic" and/or a "known bleeder", were guilty of negligence and failed to use reasonable care, skill and diligence in or about the said treatment, attendance and advice which they gave to the deceased and as a result of which she suffered much pain and distress and ultimately died.***
>
> ***<u>Particulars of Negligence</u>***
>
> ***1. Failed to heed that the deceased was a "known bleeder" and to request, consult or to have due and/or any regard for the medical record of the deceased;***
>
> ***2. Failed to do or to have done any blood investigations;***
>
> ***3. Failed to have any or any sufficient quantity of blood on hand in the event of any need for such blood and particularly so in the instant care [sic] as the deceased was a "known bleeder;***
>
> ***4. Failed to administer any or any sufficient medication to stop the bleeding;***
>
> ***5. Failed to take urgent and immediate or any reasonable steps to stop the haemorrhage once it had started;***
>
> ***6. Generally, failed to exercise all due care and diligence in the treatment of the deceased in all circumstances of the case.***
>
> ***11. By reason of the aforesaid negligence the deceased underwent***

much pain and suffering which she would not otherwise have endured and succumbed to foreseeable excessive bleeding and died as alleged aforesaid from "shock due to post partem [sic] haemorrhage" and further her estate and dependants have suffered loss and damage.

[8] The issue arose at the trial whether the particulars of negligence should be confined only to paragraph 10 of the statement of claim; that is to say, to the allegation that she was a gestational diabetic and a known bleeder. It was pursued on appeal. It is a matter to which I shall come. Indeed the issue of Mrs. Lezama being a bleeder after childbirth loomed large at the trial. Dr. Manning-Alleyne, testified to telling Dr. Achong Low at the point of emergence of the baby that *Karen was a bleeder*.

[9] In his defence, Dr. Achong Low admitted knowing that she was a gestational diabetic but denied knowing her to be a bleeder. Mrs. Lezama had had three previous uneventful deliveries, one of which he had done himself. He said she was Dr. Weithers' patient at all times prior to 6th April, 2003. He attended to Mrs. Lezama on 6th April, 2003 because Dr. Weithers was out of the jurisdiction and he had agreed to cover her practice. He visited Mrs. Lezama at approximately 11:00 a.m. on 6th April and left after giving instructions that he was to be called back when she was close to full dilation. He was called back at approximately 4:30 p.m. and upon his arrival, he entered the delivery room. At approximately 4:53 pm Karen had a normal spontaneous vaginal delivery of a *stillborn* baby boy. Almost immediately after delivery there was vaginal bleeding and there appeared to be evidence that the blood was not clotting. He directed that she be given more units of syntocinon and fluids intravenously. According to the appellant, Mrs. Lezama suffered an amniotic fluid embolism (AFE). Despite his treatment, which was in accordance with the practice accepted and recognized as proper by the body of medical practitioners skilled in the field of gynaecology and obstetrics, she died as a result of acute cardiovascular collapse and DIC caused by AFE. He denied any negligence.

Findings of the judge

[10] In effect, the judge's findings in negligence were that the appellant failed the *Bolam* test. He found negligence on three grounds:

(i) The appellant failed to take urgent and immediate steps to stop the haemorrhage once it started.

(ii) The appellant failed to administer sufficient medication to stop the bleeding.

(iii) The appellant failed to exercise all due care and diligence in the treatment of Mrs. Lezama in all the circumstances of the case.

[11] The judge itemised his findings under five heads. I have summarised his findings as follows:

(i) PPH was the cause of death. But the court was not prepared to make a specific finding as to the cause of PPH. While it was accepted by all that Mrs. Lezama died from PPH, the evidence presented did not establish either AFE or DIC as a cause of death.

(ii) There was no causal link between the deceased being a gestational diabetic and the risk of haemorrhaging post-delivery.

(iii) Mrs. Lezama was not a known bleeder having regard to the expert evidence of Drs. Singh-Bhola, Persad and Jibodh who opined that Mrs. Lezama's medical history did not disclose any predisposition to PPH and that such a history would have been reflected in her records. The judge gave no weight to Dr. Manning-Alleyne's evidence that Mrs. Lezama had suffered PPH post-delivery of her last child.

(iv) The particulars of negligence set out at paragraph 10 of the statement of claim could not be read in isolation but in the context of the statement of claim as a whole.

(v) On the issue of medical negligence, he found that:

(a) Because Mrs. Lezama was not a known bleeder, it could not be anticipated that there would be serious haemorrhaging to require the sourcing of blood beforehand. Therefore, it was not unreasonable or negligent that there was no blood on hand when the emergency presented.

(b) However, when, at the time of delivery, Dr. Manning-Alleyne told Dr. Achong Low that Mrs. Lezama had suffered PPH in the past, he ought to have taken that representation on board and acted consistently with the accepted practice in those cases, in case Dr. Manning-Alleyne's statement was accurate. Nothing less than prudence was required in the light of the information provided. This was so whether or not it was correct and despite the evidence that at 7:30 p.m. the deceased appeared to be clinically dead. More than sufficient time had elapsed between the time of birth and 7:30 p.m. during which steps should have been taken to source and administer more blood and blood products. Tests should have been performed on the deceased immediately in an effort to begin the process of sourcing blood. This means that Dr. Achong Low ought to have requested the blood at an earlier stage than that at which he did.

(c) While it was true that obtaining blood and blood products from the blood bank in a timely fashion was a difficult task at the time, it was clear that an attempt was not made within the earliest possible time. It was not sufficient simply to sit by and say that the process of obtaining blood was a difficult or lengthy one.

(d) There was ample evidence that more blood and blood products ought to have been given. Such evidence came not only from the witnesses for the respondent but also the witnesses for the appellant. On this basis, the appellant was negligent by: *"Failing to take urgent and immediate or any reasonable steps to stop the haemorrhage once it had started."*

(e) The appellant, in a situation assessed by him to be *catastrophic and sudden*, ought to have administered a dosage of the drug syntocinon which was closer to the maximum dosage of 80 units as Dr. Persad,

medical expert for the defence, testified. Although the correct drug was used, a dosage of 50 units was insufficient as Dr. Singh-Bhola testified. In the circumstances, the appellant was negligent by *"failing to administer sufficient medication to stop the bleeding."*

(f) Further, having assessed the situation as critical, the appellant ought to have enlisted assistance earlier than when Dr. Chang was called. At the time that Dr. Chang was called (around 7:30 p.m.) there was only one intravenous access in operation. Better intravenous access would have meant that blood and drugs would be administered faster, resulting in a quicker response. Calling for help was standard practice. As a consequence the appellant was negligent by *"Failing to exercise all due care and diligence in the treatment of the deceased in all the circumstances of the case."*

[12] The judge found that the testimony of all the medical practitioners pointed to the administering of more blood and blood products at an early stage as an accepted method of treatment of PPH. He found this to mean that the earlier the patient is given an adequate supply of blood and blood products, the more likely the patient is to survive an onset of PPH. He accepted Dr. Singh-Bhola's opinion that the sooner blood and blood products are replaced, the less the risk of organ damage and death. He held that it followed that it is more likely than not that the failure to administer more blood and blood products in a timely fashion resulted in the death of Mrs. Lezama from PPH. In this regard, he specifically rejected the evidence of the appellant that the infusion of more blood would not have made a difference.

[13] The broad question is whether these findings are supported by the evidence and the law.

<u>Summary of Decision</u>

[14] The appeal is dismissed for the following reasons:

(i) The judge was correct to find that paragraph 10 of the statement of claim should be read as a whole. The particulars at paragraph 10(4), (5) and (6) cannot be limited only to the allegations set out in the general body of that paragraph. In this case, they particularise what the entire claim is founded upon, greater details of which are to be provided in the witness statements.

(ii) The trial judge committed three material errors. First, by failing to decide on whether the appellant did diagnose AFE and whether such a diagnosis was reasonable, he failed to consider a major part of the appellant's case. Second, the judge was wrong to have held that Dr. Manning-Alleyne's statement at the moment of delivery, that Mrs. Lezama was a bleeder, should have caused the appellant to act upon it. Third, the evidence did not support his conclusion that Dr. Achong Low had administered insufficient dosages of syntocinon.

(iii) These three errors were material errors which entitled the Court of Appeal to look at all of the evidence afresh and come to its own conclusion. Having looked at the evidence afresh I find that, despite these errors, the trial judge's analysis of the appellant's standard of treatment of Mrs. Lezama was largely correct and he came to the correct conclusion on all three heads of negligence.

(iv) The respondent's counter notice on costs is also dismissed.

<u>The constraints of appellate review</u>

[15] The constraints on an appellate court when reviewing the findings of fact of the judge at first instance are well established. The judge enjoys the advantage of having heard and seen the witnesses. The Court of Appeal has only the printed evidence. As de la Bastide CJ said in **Carol Ettienne v. Thelma Ettienne, Civil Appeal No. 116 of 1996** at page 8:

> ***"For his finding to be upset there must be some demonstrable flaw in the process by which he reached it. It may be for instance that***

> ***he drew an inference which was not justified or failed to draw an inference which was. Another ground on which the appeal court may interfere is that the trial judge failed to take account of some relevant piece of evidence or to appreciate its proper significance, or conversely that he took into account something which he ought not to have taken into account or attributed to it a significance which it did not rightly have."***

[16] Lord Hodge, in **Beacon Insurance Co. Ltd. v. Maharaj Bookstore Limited [2014] UKPC 21**, **[2015] 1 LRC 232**, said at paragraph 12:

> ***"The court is required to identify a mistake in the judge's evaluation of the evidence that is sufficiently material to undermine his conclusions."***

[17] There is also the dictum of Lord Reed (at paragraph 67) in **Henderson v. Foxworth Investments Ltd. [2014] UKSC 41, [2014] 1 WLR 2600**, cited with approval in the recent decision of the Privy Council in **Paymaster (Jamaica) Limited & Anor. v. Grace Kennedy Remittance Services Limited [2017] UKPC 40** at paragraph 29. Lord Reed said:

> ***"in the absence of some other identifiable error, such as (without attempting an exhaustive account) a material error of law, or the making of a critical finding of fact which has no basis in the evidence, or a demonstrable misunderstanding of relevant evidence, or a demonstrable failure to consider relevant evidence, an appellate court will interfere with the findings of fact made by a trial judge only if it is satisfied that his decision cannot reasonably be explained or justified."***

[18] I am also particularly mindful of the additional dictum of Lord Reed cited by Lord Hodge in **Beacon**. At paragraph 15, Lord Hodge said:

> ***"There are further grounds for appellate caution. In McGraddie v. McGraddie [2013] UKSC 58, [2013] 1 WLR 2477, 2014 SC (UKSC) 12, Lord Reed (at para 4) cited observations adopted by the majority of the Canadian Supreme Court in Housen v. Nikolaisen [2002] 2 SCR 235, para 14:***
>
>> ***'The trial judge has sat through the entire case and his ultimate judgment reflects this total familiarity with the evidence. The insight gained by the trial judge who has lived with the case for several days, weeks or even months may be far deeper than that of the Court of Appeal whose view of the case is much more limited and narrow, often being shaped and distorted by the various orders and rulings being challenged.' "***

[19] In this case, the trial proceeded over a period of five days. There was vibrant cross-examination of witnesses on both sides. The judge had an active role in the exchanges between counsel and witnesses. He was very much a part of the cut and thrust of the proceedings with a keen eye and ear for what was happening in the courtroom.

[20] The judge's findings are challenged by the appellant on multiple grounds. They can be summarised as challenges to his acceptance of the evidence of Professor Daisley, his reliance on the statement of Dr. Manning-Alleyne to Dr. Achong Low that Mrs. Lezama was a bleeder, his refusal to confine the particulars of negligence to paragraph 10 of the statement of claim, his refusal to hold that AFE was a cause of death and his findings on medical negligence.

The pleading challenge

[21] The judge held that paragraph 10 of the statement of claim should be read in the context of the entire statement of claim. He was entirely correct. Certainly it was a central part of Mr. Lezama's claim in negligence that Mrs. Lezama was a gestational diabetic and a bleeder but there is no good reason to confine all of the particulars to those contentions. The particulars at paragraph 10(4), (5) and (6) cannot be limited only to the allegations set out in the main body of paragraph 10. They set out in more general terms the basis upon which the overall claim is founded. Greater details of the overall claim are then provided in the witness statements.

The substantive appeal

[22] The other challenges and the substance of this appeal all relate to the judge's findings on medical negligence. The question is whether he was plainly wrong in so far as he may have made errors which materially affected his findings. It requires a review of the evidence. While a judge has a panoramic view of the dynamics of the courtroom, that advantage is diminished in this case by the fact that much of the evidence given is expert evidence in which substance (logic and knowledgeability) trumps demeanour. It is further attenuated by the fact that a large part of the supporting evidence is documentary and undisputed. As Lord Hodge (at paragraph 17) put it in **Beacon**:

> ***"The form, oral or written, of the evidence which formed the basis on which the trial judge made findings of primary fact and whether that evidence was disputed are important variables. As Lord Bridge of Harwich stated in Whitehouse v Jordan [1981] 1 WLR 246, 269-270:***
>
> > ***"[T]he importance of the part played by those***

> ***advantages in assisting the judge to any particular conclusion of fact varies through a wide spectrum from, at one end, a straight conflict of primary fact between witnesses, where credibility is crucial and the appellate court can hardly ever interfere, to, at the other end, an inference from undisputed primary facts, where the appellate court is in just as good a position as the trial judge to make the decision."***

See also Lord Fraser of Tullybelton, at p 263G-H; Saunders v Adderley [1999] 1 WLR 884 (PC), Sir John Balcombe at p 889E; and Assicurazioni Generali SpA v Arab Insurance Group (Practice Note) [2003] 1 WLR 577 (CA), Clarke LJ at paras 12-17. Where the honesty of a witness is a central issue in the case, one is close to the former end of the spectrum as the advantage which the trial judge has had in assessing the credibility and reliability of oral evidence is not available to the appellate court. Where a trial judge is able to make his findings of fact based entirely or almost entirely on undisputed documents, one will be close to the latter end of the spectrum."

<u>The evidence</u>

[23] The sequence of events leading up to Mrs. Lezama's death began on the morning of 6th April, 2003 at around 8:30 a.m. Dr. Weithers had left the country and Dr. Achong Low had agreed to undertake her medical care. There were four witnesses who were present in the delivery room during the emergency: Brian, Dr. Achong Low, Dr. Petronella Manning-Alleyne and Dr. Harold Chang. Dr. Chang arrived at the medical facility quite late in the day. I shall reproduce their respective accounts as fully as possible because they give a vivid picture of the emergency as it unfolded. The nurses' note of 6th April, 2003 states as follows: *"8:30 a.m. Re-admitted Hx of Decreased Foetal Movement" "Foetal heart not*

heard. 9:00 a.m. Dr. Achong Low informed". A note of Dr. Achong Low, (however incomplete) written immediately subsequent to Mrs. Lezama's death, summarizes (for the most part) from his perspective the delivery and subsequent emergency in these terms:

> ***"6/4/13 Postpartum Note***
>
> ***Patient demised @ 10:10 pm after delivery occurred @ 4:53 pm. Almost immediately upon delivery of a peeling SB (stillbirth) XY (boy), there was significant bleeding which after repair of a median laceration at the post (posterior) fourchette, the PPH (postpartum haemorrhage) was controlled by IV (intravenous) Syntocinon drip and fundal massage (∽ [about] 500 cc).***
>
> ***However the BP (blood pressure) was shocking (systolic 40 - 70) and the PR (pulse rate) ↑ (increasing) and thready.***
>
> ***Whole blood obtained and hung, but VS (vital signs) began to deteriorate rapidly.***
>
> ***Dr. H. Chang was called and when the pulse stopped, EX (external) cardiac massage commenced and bag X ambu (ambu bag).***
>
> ***7:30 pm Upon Dr. Chang's arrival - Defib (defibrillation) applied and meds given. Fluids and hemacel pushed. o/e (on examination) then, pupils fixed and dilated. Heart rate obtained 132, SR tachy and O_2 sat 97. Decision to transfer to ICU (Intensive Care Unit) for further management. But patient began to bleed again x̄PV(extremely per vagina) and from all venipuncture sites and orifices.***
>
> ***… HR (heart rate) ↓ (decreasing) and irregular. Unable to restore***

SR by … attempts to resus (resuscitate) halted @ 9:4….”

His witness statement (as relevant) was as follows:

10. I was next paged at approximately 4:30 p.m. and when I arrived there, at about 10 minutes after, the patient had already been taken to the delivery room. At that time she was almost fully dilated. Upon entering the delivery room I saw her husband, Brian Lezama, and Dr. Petronella Manning and the nurse present. I recall having to rush to be gowned and gloved because the patient was experiencing a great urge to bear down...

11. The second stage of labour occurred quickly. There was a normal spontaneous vaginal delivery which occurred at 4:53 p.m., that of a still birth baby boy 8 lbs, 6 ounces. The placenta was then delivered. There was also a small posterior fourchette laceration and I repaired this. That took about 3 minutes. While delivery was going on she was administered Syntocinon, which is an oxytocic drug which stimulates uterine contractions.

12. Almost immediately post delivery of the peeling still birth there was significant per vagina bleeding, which I estimated to be approximately 500 cc. The blood was pale, pink, and watery, not bright red, and was not clotting. The fact that the blood was not clotting in my experience usually is an ominous sign indicating a possible intravascular coagulopathy.

13. During delivery one will try to limit the amount of blood loss. The expected average volume of blood loss during delivery is about 200 to 300 cc. When there is about 500 cc or more of blood loss there is the need for even greater care. The definition of post partum hemorrhage is loss of 500 cc or more.

14. As I stated above, the delivery occurred quickly at 4:53 p.m. and the placenta was delivered immediately after and was complete and spontaneous. Upon realizing that there was this amount of blood loss I began to take steps to arrest it. Syntocinon was already administered at the delivery of the baby in order to achieve contraction of the uterus and therefore to diminish blood loss. On my instructions the nurse administered an additional dose of 10 units of Syntocinon intravenously in an attempt to curtail blood loss …

15. At 5 p.m. 20 units of Syntocinon were added to the 300 mls of IV infusion. At 5:15 p.m. another litre of fluid, ringers lactate, was placed and another 20 units of Syntocinon were placed as well. The reason ringers lactate was being administered was to attempt to expand the intravascular volume of the patient, in other words the volume in the patient's circulatory system.

16. At 5:15 p.m. the patient had lost less than an additional 300 cc of blood. At about that time the patient's blood pressure fell to 41 over 32 which indicated that she was in shock. Any patient going into shock after the loss of 800 cc of blood within 22 minutes is highly atypical, unless there is some other underlying factor. As I said above, the blood was not clotting and when I saw the blood was not clotting, due to my experience, I presumed that I had to be dealing with some sort of consumptive coagulopathy which is something that occurs in the presence of amniotic fluid embolism.

17. Karen Lezama's blood pressure loss/drop, as outlined above, could not be explained by blood loss. I diagnosed her as having an amniotic fluid embolus. An amniotic fluid embolus occurs when during labour, amniotic fluid, because of the

contraction of the uterus, gets squeezed into the vessels of the uterus which then goes into the lungs and creates a significant reaction in the individual. This reaction takes the form of a combination of acute respiratory distress, acute cardiovascular collapse and usually a coagulation defect, which means that the patient has difficulty clotting and is at much greater risk of bleeding. Her blood pressure drop, loss of blood, blood not clotting etc. was pathogonomic, which means it is absolutely typical of "amniotic fluid embolism" and its attendant sequelae, or complications that come thereafter. The patient had presented no symptoms prior to delivery to indicate that an amniotic fluid embolus may have occurred. The occurrence of such an event may occur at the actual delivery process itself.

18. An amniotic fluid embolus is devastating with more than 50% mortality. It is a statistical occurrence, it cannot be prevented. I personally have attended at least 5 cases of this nature of which I am happy to say that all, except, one person, survived. The person who died after delivering did not have any significant bleeding at delivery and after delivery she went back into her bed, sat up, spoke to the nurse and then fell dead.

19. Because of the blood loss I instructed that the patient be also administered a blood substitute. At 5:15 p.m. the 1st unit of blood substitute, haemacel, was hung in the IV. A foley catheter was inserted into the bladder which gave evidence of blood stained urine. A foley catheter is inserted when someone goes into shock to monitor the volume of urine production over time as a reflection of the perfusion of the kidneys according to the blood pressure existing then. Blood stained urine is not normally produced when a catheter is placed in the bladder and therefore that gave me further presumptive evidence that there may have been some sort

of coagulopathy problem ongoing at the same time.

20. The normal and accepted things that one would do to control "post partum hemorrhage" would be to use oxytocics, to massage the uterine fundus, to ensure there are no vaginal lacerations actively bleeding, and to replace blood loss and to give a volume expander. All of which were done.

21. After delivery, the patient's fundus was being massaged continuously by the nurse. We did succeed in getting the blood pressure back up. At 6:15 p.m. her blood pressure was recorded as 103/67 and her pulse was 90 bpm. That was reasonable and we were observing the patient still because at this stage, the bleeding was not significant.

22. I also obtained 2 units of blood for her. The first unit was started at 7:36 p.m. This blood was only obtained because of my intervention otherwise we would not be able to get blood at Stanley's. Stanley's did not carry any blood units. I was able to obtain these units because I demanded it from St. Clair Medical an institution in which I have a relationship.

23. Between 5:15 p.m. and 9:45 p.m. the 2 units of blood were given and 7 units of haemacel were given, in addition to volume expanders like ringers lactate and normal saline. There was no shortage of volume expanders and blood substitutes utilized ...

(That latter statement at paragraph 23 is misleading however because, as will be seen from Dr. Chang in his witness statement, only three units of fluid were given to Mrs. Lezama between 5:15 p.m. and 7:30 p.m. (when he arrived). By about 7:30 p.m., Mrs. Lezama was described by Drs. Manning-Alleyne and Singh-Bhola as already basically dead.)

28. The patient was pronounced dead at 10:10 p.m., despite my best efforts. On the death certificate I stated the primary cause of death as being disseminated intravascular coagulopathy. I explain this as follows, in the blood stream there are lot of blood factors that are involved in the clotting mechanism. In certain conditions all of these clotting factors are consumed and because you have a depletion in the level of clotting factors, the patient can begin to bleed, be it from, trauma, incisions or spontaneous occurrence. One of the conditions where disseminated intravascular coagulopathy can occur is with an amniotic fluid embolism ... The secondary cause of death was postpartum haemorrhage.

[24] Brian in his evidence described the ensuing event a lot more dramatically:

17. On entering the delivery room Karen was in a position on the delivery table for delivery. Everything seemed "normal" as with the birth of our three other children (the last of [whom] was delivered by Dr. Achong Low in 1995) as I was present in the delivery of all their births. Dr. Manning-Alleyne was present as well as nurses. Dr. Achong Low was not present at this time. The baby's head was emerging and the nurse had almost delivered the baby completely when Dr. Achong Low appeared through the doorway of the delivery room. Dr. Manning-Alleyne immediately told Dr. Achong Low that Karen had experienced Postpartum Haemorrhage with her three previous deliveries. Dr. Achong Low reached just in time to remove the baby from the birth canal and as soon as he did so and removed the placenta a gush of blood and fluid gushed out covering all in its path.

…

19. Karen was haemorrhaging profusely. At this time Dr. Achong Low gave instructions for the nurses to rub her tummy and this would stop the haemorrhage after some time. He continued stitching with great difficulty. Dr. Achong Low complained again that Karen was bleeding so heavily that he could not see properly to do the stitching. While still holding the baby I noticed at this time there was a pan (one in which food for a buffet is served) of soiled linen under the delivery table used to catch the fluids drained from the delivery table was overflowing the linen in it was fully drenched with blood, and was overflowing into a river of blood on either side of the table.

20. At this time also, Dr. Achong Low was still stitching as the nurse rubbed Karen's belly. Dr. Manning-Alleyne turned to Dr. Achong Low and asked if he needed to use Haemacell and he said "not at this time". He said he would continue to rub-up the belly. The river of blood at this time had reached at least 3 to 4 feet in either direction from the delivery table. I noticed that the blood seemed not as a thick red as I noticed before but a clear watery consistency. Karen was moving about restlessly on the table.

…

22. Dr. Manning-Alleyne looked very concerned and told the nurses that she was going to draw some blood to run some quick tests and proceeded to do so. Dr. Achong Low returned and continued to rub-up Karen's belly alternating with a nurse. A blood pressure monitor was setup at this time … Dr. Achong Low kept questioning the nurses constantly about the readings and became so frustrated at one point asked for the machine to be replaced with another one …

23. ***At this time a man appeared by the labour room door and pushed his head in and asked Dr. Achong Low if he needed assistance and Dr. Achong Low abruptly declined "No". The following day I found out that the man was Dr. Ajit Kuruvilla … At this time Dr. Achong Low noted that he would have to send for some blood. Dr. Manning-Alleyne retuned to the labour room and then called my attention to Karen telling me that she was calling my name. I was in shock as a by-stander everything was happening fast and furious around me I could only see blood everywhere.***

24. ***Karen called to me again and I went close to her side, she seemed very weak and pale and her breathing was very shallow. I had to strain to [h]ear what she was trying to say. Then she said her last words to me "Brian, Daniella Marisa Justin" and said no more. Her eyes turned up to me into a blank stare and I tried to talk to her she did not respond, I looked at her again, she was very pale. I then became even more frightened and called out to Dr. Manning-Alleyne "Karen is not responding to me!" Dr. Manning-Alleyne checked Karen's eyes and tongue and alerted Dr. Achong Low to her condition to which he seemed unaware. Dr. Manning-Alleyne left the labour room. Karen was now unconscious, bleeding on the table with a nurse and Dr. Achong Low rubbing her belly. Blood had not reached yet. I tried speaking to Karen about five times again and again got no response, just a blank stare. At this point Dr. Achong Low asked me to leave the labour room. It was now about 7:00 p.m.***

25. ***When I entered the hallway to the reception desk of the nursing home I saw Karen's mother and some other friends of the family praying and held on to her telling her that Karen was not responding. I was informed that Dr. Manning-Alleyne and Fr.***

Matthew (Karen's brother) left for St. Clair Medical Clinic for some time now to try to acquire some blood. After a short time, I wandered back into the labour room. Dr. Manning-Alleyne had returned and was massaging Karen's chest and Dr. Achong Low was still rubbing Karen's belly. I stood just inside of the doorway of the delivery room inconspicuous to the doctors for some time with disbelief of what was taking place. Dr. Achong Low then noticed me standing there and again asked me to leave. I left the labour room for the second time sat down in the hallway with Karen's mother and prayed.

…

27. Not long after I left the labour room the doctors came out into the hallway and asked that the immediate family come into and [sic] adjoining private room to have a conference. When the family gathered in the room Dr. Achong Low, Dr. Harold Chang and Dr. Manning-Alleyne were present. Dr. Achong Low spoke first, he told us that Karen's condition was deteriorating and that he wanted to get her hooked up on a respirator. He went on to explain that there was labour unrest in the Mount Hope and the General Hospital in Port of Spain so he was suggesting that St. Clair Medical may be the best option at this time as the other medical institutions may not have anyone to setup the instruments because of the unrest. The only thing he explained about St. Clair Medical was that a downpayment of $25,000.00 must be made on admission. It was about 9:30 pm. Sunday night. Then Dr. Chang spoke. He said that he only came as a favour to Dr. Manning-Alleyne and on arrival he saw a flat line on the monitor. He eventually after many trials got a good vein in which to administer some blood and she was somewhat responding to his efforts.

28. It was at this time that the meeting was cut short as a nurse summoned the doctors back into the delivery room. I also followed then [sic] into the delivery room. It seemed to me that Karen had gone into a cardiac arrest this was about 9:40 p.m. Dr. Achong Low began to massage her chest as the nurse squeezed the respirator bag over her face. Dr. Manning-Alleyne asked me to assist her and showed me what to do then, she went to set up the paddles for Dr. Achong Low. Dr. Achong Low shocked Karen then looked at the monitor, which seemed to me to have a very faint heartbeat line. He then shocked her again but this time there was a flat line. He shocked her repeatedly again and again. The nurse took over the squeezing of the respirator from me as the other doctors looked on. Dr. Achong Low tried in vain over and over again as the nurse continued to work the respirator. The nurse also shook he head as if to signal doctor it is over, but her continued for a while again until he just walked out of the labour room leaving me and the nurse in there. It was now about 10:10 p.m.

29. Soon after Karen's mother joined me in the labour room. The nurses asked us for some clothes to dress Karen and the baby into. After sometime we left the labour room. As I left the labour room, I saw a crowd of family and friends out in the halls and I proceeded to the nurse's desk where I saw Dr. Achong Low and Dr. Manning-Alleyne. I heard Dr. Manning-Alleyne ask Dr. Achong Low "What about the autopsy, surely doctor this is a coroner's case?" He replied "No" and continued to fill out notes and the death certificate. I then went to Karen's mother side to console her as she had collapsed. The family and I waited around for some time for the funeral home to come to collect Karen and the baby to take them to the funeral home.

30. I did not see or hear from Dr. Achong Low for some weeks after that day.

…

32. After about one month had passed and not having heard from Dr. Weithers or Dr. Achong Low I decided to call Dr. Achong Low's office (as I believed Dr. Weithers was still out of the country) to make arrangements to settle any bills which may have been incurred. Karen's mother and I went to Good Health Medical Centre and entered Dr. Achong Low's office. I first asked the question "what had caused Karen's eventual death?" He began to speak and said that he believed it could have been an amniotic Embolism, which occurred, but there was no conclusive evidence to prove this was the case so he wrote "Post Partum Haemorrhage" on the Death Certificate. He also said that an autopsy was not performed so he was not sure of his diagnosis and this is why he wrote "Haemorrhage and D.I.C. (Disseminated Intra-vascular Coagulopathy) Stillbirth'.

Dr. Petronella Manning-Alleyne

[25] Dr. Manning-Alleyne stated that she had been Karen's paediatrician during her previous three pregnancies. She stated that Karen usually suffered post-partum haemorrhage (PPH). On April 6th 2003, Karen called her and told her that she had not felt the baby move. Dr. Manning-Alleyne instructed her to go to the nursing home. She subsequently spoke by telephone to a nurse at the nursing home who told her there was no heartbeat. According to Dr. Manning-Alleyne, Dr. Achong Low informed the parents that the baby was dead and that a vaginal delivery was appropriate. Karen was transferred to the delivery room. Around 4:40 pm., Dr. Achong Low arrived at the delivery room just as the baby was emerging. She told him of Karen's history of PPH. She added that *"He appeared*

not to have known of the deceased's history as he asked me, 'Is that so?' " She said that the baby appeared to have been dead for about three days because it was macerated.

[26] She said that as soon as Karen delivered she started to bleed profusely. The appellant and the nurse began to knead her abdomen. Dr. Manning-Alleyne offered to do whatever she could to assist and the appellant told her that she could rub Karen's belly. More syntocinon was put into an intravenous (IV) drip. The nurse told her there was a limited amount of syntocinon and asked her if she could assist in getting some. Dr. Manning-Alleyne offered to go to the Port of Spain General Hospital to get some more of the medication. On her way out of the facility she saw Dr. Ajit Kuruvilla. She told him that the appellant had a patient with PPH. Dr. Kuruvilla said he would go back and assist. When she got back to Stanley's Dr. Kuruvilla was no longer there. By this time it was three hours after the delivery and no blood had been taken from Karen for cross-matching. There was still only one IV line. No blood or blood products had been given. She made suggestions but none of these suggestions were acted upon and *there seemed to be no urgency*.

[27] At about 7:30 pm, she asked Dr. Achong Low to give Karen some blood. The appellant left and went to the telephone, then returned and tried to get a specimen of blood for matching. No volume expander was being used. Dr. Achong Low stated that the St. Clair Nursing Home had two pints of blood and he asked Father Matthew D'Hereaux to get the blood. Father Matthew D'Hereaux transported Dr. Manning-Alleyne to St. Clair Medical Clinic and she collected the uncrossmatched blood. She was out of the room for twenty minutes. Before she left to get the blood, Karen was restless and *shocky*, she was being bagged with oxygen and her heart rate was slow. She asked if she could start cardiac massage and Dr. Achong Low agreed.

[28] She also asked if she could call Dr. Harold Chang, an anaesthetist. The appellant agreed. Dr. Chang arrived and gave instructions to intubate the patient

and start her on haemaccel. Dr. Chang assisted with putting up a second IV line. However, Karen's blood was not infusing. Only part of the first bag was given. Dr. Chang managed to get Mrs. Lezama's heart beat to come back up and said that she needed intensive care. Dr. Chang, the appellant and Dr. Manning-Alleyne then spoke to the family about the need for intensive care. When they went back into the room Mrs. Lezama started *"arresting"*. She died at 10:10 pm. According to Dr. Manning-Alleyne, the appellant started to complete Mrs. Lezama's death certificate. She suggested that an autopsy should be done. The appellant said "No" and finished writing the death certificate. She then wrote the death certificate for the baby.

[29] Dr. Manning-Alleyne was challenged in cross-examination by Mr. Young, then counsel for Dr. Achong Low on several of her assertions. He pointed out to her that contrary to her assertions that no blood had been taken from her for cross-matching some three hours after the stillbirth, blood was taken from Karen at 6:40 p.m. He also pointed to the fact that Ringer's lactate, which was a volume expander, was given to Mrs. Lezama at 5:15 p.m. So too, was haemaccel. Dr. Manning-Alleyne accepted that haemaccel was also a volume expander. She also accepted that the nurses' notes stated that at 6:40 p.m. blood was taken from Mrs. Lezama for group and cross-matching. In re-examination, she challenged the accuracy of the notes, if not their credibility. She suggested that the notes were inaccurate because in her recollection no haemaccel was given and that the notes were written retrospectively.

<u>Dr. Harold Chang</u>

[30] Dr. Harold Chang in his witness statement was clinical and to the point. His evidence was quite instructive. He stated as follows:

> ***(1) On Sunday 6th April 2003 at around 7:30 p.m. I received a call from Dr. Manning-Alleyne who asked me to come to Stanley's Nursing Home to assist her friend, a patient, at Stanley's Nursing***

Home. Dr. Achong Low was the attending obstetrician and had agreed for me to come to assist.

(2) I attended immediately and on my arrival about 15 to 20 minutes later I went into the delivery room. There were a lot of persons in the room and the place and atmosphere was chaotic. There were two drips up but only one was working. The patient who I later found out was Karen Lezama was comatose and had a cardiac arrest. The patient was being resuscitated via external cardiac massage and ventilated manually via Bag/Mask. The patient was also being given blood.

(3) My immediate reaction was to continue to implement the ABC's of resuscitation i.e. Airway, Breathing, Circulation. The airway was secured by inserting an endotracheal tube to make ventilation more effective, I also asked for the ECG monitor to be started.

(4) Attention to her Circulation was next. The working diagnosis was post-partum haemorrhage and the aim was to resuscitate her adequately by volume replacement of fluids of non-blood products and blood. Another intravenous access was put up via a central venous catheter and intravenous fluids run in.

(5) She was defibrillated at 8:25 p.m. and a heart rate of 132/minute and oxygen saturation of 98% was recorded at 8:40 p.m.

(6) There were no haemoglobin tests done. The patient had been given three litres of fluid between the hours of 5:15 p.m. and 7:25 p.m. and the urine output was only 20 ml. This informs me that the intravenous resuscitation effort was not adequate and the patient was not adequately hydrated. If a patient is adequately hydrated the urine output would be at least ½ ml per kilogram per hour i.e. 35 mls/hour for a 70 kg adult.

(7) After her resuscitation for her cardiac arrest, ventilation and other supportive therapy was continued and a decision was

made that the patient had to be taken to an Intensive Care Unit.

(8) Her condition continued to deteriorate and she arrested again and resuscitation efforts were restarted at 9:36 p.m. by Dr. Achong Low. The patient was pronounced dead at 10:10 p.m.

(9) I did not make notes of my attendance at Stanley's Nursing Home but I have refreshed my memory from the notes of the nurse, the doctor and the charts which are in the agreed bundle filed in the Court.

There was no challenge to the substance of Dr. Chang's evidence in cross-examination.

[31] The question of medical negligence came down to a battle of the experts; the three obstetrician/gynaecologists and a pathologist in the person of Dr. Hubert Daisley. They all gave their written opinion in response to questions posed and were cross-examined. None of them knew the patient. Their opinions were based on the documentary information provided to them. Their evidence went to establishing whether the treatment administered by the appellant accorded with a practice accepted as proper by a responsible body of medical men skilled in that particular field. I would say that this criteria put Dr. Daisley at an immediate disadvantage because he was not an obstetrician/gynaecologist.

Dr. Singh-Bhola

[32] Dr. Singh-Bhola, a consultant obstetrician and gynaecologist and clinical lecturer testified for Brian. She was asked to give her opinion on several issues. They were not all relevant to the issues in this appeal. At the time of giving evidence she had been practising for four years and this was solely in Trinidad and Tobago at the Mt. Hope Maternity Hospital, the St. Augustine Private Hospital and at the San Fernando General Hospital, where she was an intern and house officer. She was by far the most junior obstetrician and gynaecologist of the three obstetrician/gynaecologists who gave evidence. But, in my judgment, even

on the printed evidence she was quite compelling.

[33] Dr. Singh-Bhola was asked a number of questions which she addressed in a report which was detailed and objective. I have read and considered it. It is not necessary to reproduce all of its contents. I shall summarize her responses in so far as they are relevant to the issues. Her opinion supported the use of syntocinon or more generally oxytocin as an appropriate drug to manage and stem the haemorrhaging (so did Drs. Persad and Jibodh). She deposed that the most common cause of PPH is uterine atony (a soft non-contracted uterus). The use of oxytocic agents such as syntocinon would help to achieve contraction. This too was supported by Drs. Persad and Jibodh. Dr. Singh-Bhola stated that, based on the documents provided, there was no evidence to suggest that Mrs. Lezama had a history of PPH. Dr. Persad's and Dr. Jibodh's evidence was to the same effect.

[34] She stated that management would involve several steps which had to be undertaken simultaneously. Extra personnel should be called. It would also be necessary to contact the blood bank and the anaesthetist in case surgical intervention was necessary. The patient's airway and breathing should be assessed. A high concentration of oxygen via a facemask should be administered. The circulation must be evaluated. Intravenous access should also be established to take blood for full blood count, coagulation screen, urea and electrolytes, and crossmatching. It would be necessary to commence infusion of crystalloid solutions such as normal saline or Ringer's lactate followed by infusion of colloids such as Haemaccel. Where there is a significant amount of blood volume lost, replacement of clotting factors such as fresh frozen plasma, platelet concentrates and cryoprecipitate is necessary. A foley's catheter should be inserted into the bladder to monitor the urine output. The patient's condition should be continuously monitored. An assessment of the cause of the bleeding must be made by clinical examination. Management is then directed to the underlying cause. Measures that can be used are simple non-medical interventions such as uterine massage, medical interventions such as use of oxytocic agents and surgical interventions such as hysterectomy. If the source of the bleeding is a

coagulation disorder then replacement of the blood and clotting factors is essential.

[35] Dr. Singh-Bhola stated that it is *"the clinical picture"* that should be the main determinant of the need for blood and blood product transfusion. While laboratory results may help in guiding the clinician, time should not be wasted waiting for these results. The sooner blood and blood products are replaced, the greater the reduction in the risk of organ damage and death.

[36] She found the following aspects of the care provided to have been substandard:

- The appellant failed to call for help in a timely manner. Despite the fact that an anaesthetist would have been invaluable, for example, in helping with resuscitation, maintaining the patient's airway and inserting lines, he was not called until two and a half hours after the delivery
- The resuscitation was inadequate. Only three litres of fluid were given during the first two hours after delivery. The fact that the patient remained cold, clammy, tachycardic, hypotensive and had little urine output would indicate that fluid replacement was inadequate. Even though seven units of colloids (haemaccel) were eventually given, most of this was after the first two hours. By this time the patient's condition had deteriorated significantly. Further, insufficient blood was given. Volume expanders (haemaccel) and blood were not given in a timely manner.
- No request was made for clotting factors. She said that *"if the cause of bleeding is due to a coagulation disorder (lack of clotting factors as in DIC) then replacement of blood and clotting factors is essential"*. The blood which was transfused would have been packed red blood cells and not whole blood. It would not have contained any clotting factors. Fresh frozen plasma which contains clotting factors should have been requested at an early stage especially as the appellant said he recognised immediately that it was a case of DIC. She was challenged in cross-

examination by Mr. Young and conceded that she had no reason to doubt that Dr. Achong Low had received *whole blood* which would have had all the clotting factors.

- She stated that while syntocinon was rightly used to encourage uterine contraction, the amounts used were insufficient. Challenged by Mr. Young in cross-examination on this issue, she held to her position that it was not given in sufficient quantity.
- She did suggest surgical intervention as an option. This suggestion was shot down in cross-examination and she conceded that she would not have pursued it because of the patient's unstable condition.

[37] Dr. Singh-Bhola also listed factors which made Dr. Achong Low's diagnosis of AFE questionable:

(i) There was no evidence of cyanosis (bluish discoloration of the skin from lack of oxygen) which is often seen in patients with AFE.

(ii) The appellant stated that the degree of shock was not in keeping with the amount of blood lost and that the profound hypotension was due to AFE, not massive PPH. If this was the case, the patient's mucous membranes would have been pink and not pale as was stated in the nurses' notes. The patient's pallor would have suggested significant blood loss. The patient was cold, clammy, restless, tachycardic and hypotensive. These are all classic features of hypovolemic shock. (This was a hypothesis also suggested by Professor Daisley.)

(iii) If the PPH was due to DIC secondary to AFE, the uterus would have been bleeding but well contracted. The measures instituted – continuous administration of oxytocin, rubbing the uterus continually for several hours after delivery – would not have been needed if the PPH was due to DIC secondary to AFE. These measures would have suggested uterine atony, which is the most common cause of PPH. This opinion was supported by the

appellant in cross-examination when he conceded that DIC could not be controlled by fundal uterine massage.

[38] Dr. Singh-Bhola concluded that it would not have been possible, without a post-mortem, to say conclusively whether this was a case of AFE. She opined that while AFE was a possibility, the more likely possibility was that of massive PPH leading to DIC and ultimately death. She stated that PPH was not predictable or avoidable in this case. Once it occurred however it was not managed to a standard that was accepted as proper by the body of medical practitioners skilled in the field of obstetrics and gynaecology.

[39] Under cross-examination, Dr. Singh-Bhola conceded that it was not unreasonable of Dr. Achong Low to conclude that an AFE had occurred in this case. She insisted however that in an emergency situation in which she was trying unsuccessfully to extract blood from a patient whose veins were collapsing, she would call for help certainly from an anaesthetist *"simply because they put up intravenous lines all the time and they are much better at getting blood than most other doctors are"*.

[40] Dr. Singh-Bhola also held to her view that blood fluid replacements were not given quickly enough. She said although haemaccel was given, it was given after the patient had deteriorated significantly.

Professor Hubert Daisley

[41] Unlike the other three experts, Professor Daisley is a pathologist. As he ultimately conceded in cross-examination his job is to opine on cause of death *after* a post-mortem examination. He was asked by attorneys-at-law for Mr. Lezama to provide an expert opinion. He dealt with the following matters:

1. *The possible cause/causes of the death of Mrs. Lezama and whether the circumstances warranted a post mortem examination.*

2. *The possible cause/ causes of DIC given the fact that the deceased was a gestational diabetic who delivered a stillborn macerated infant.*

Professor Daisley's evidence needed to be approached with caution. He is not an obstetrician/gynaecologist. Most of his evidence was highly speculative, given that he was a pathologist and that no autopsy had been performed in this case. Professor Daisley stated that Mrs. Lezama died from hypovolemic (loss of large volume of blood) shock following PPH. He listed the possible causes of PPH as:

(i) Uterine atony (the inability of the uterus to contract);

(ii) Trauma from the delivery;

(iii) Retention of tissue from the placenta or foetus; or

(iv) Bleeding disorders.

[42] He submitted that Mrs. Lezama had uterine atony. This was her fourth pregnancy and she would have had a lax uterus, which would have contributed to uterine atony. Her uterus was unable to contract despite the administration of syntocinon and the appellant's massage of her uterus. He concluded that uterine atony contributed to the bleeding and the death of Mrs. Lezama. Professor Daisley also noted that there was trauma to the vagina. It was stated in the clinical notes that there was a laceration following the delivery of the stillbirth. It was possible that the laceration might have extended into the peritoneum where bleeding would occur undetected. An autopsy would have confirmed this finding.

[43] He stated that amniotic fluid embolism (AFE) was one of a number of conditions which causes DIC and PPH. He added that there were a few other conditions which would have caused DIC and PPH but "*It is difficult to disprove these other conditions ..., in the absence of an autopsy"*. He added that *"in the absence of an autopsy, the cause of death written by Dr. Achong Low is only speculative."*

[44] Professor Daisley said that the oozing from vein puncture sites observed in Mrs. Lezama's case may not have occurred as a result of DIC but due to a

lowered osmotic pressure from the lack of blood in her circulation, viz. hypovolaemic shock. In Professor Daisley's opinion, an autopsy was mandatory in this case since maternal death during childbirth is considered a coroner's case. He also stated that an autopsy should have been done on the infant to determine the cause of death. Mrs. Lezama's cause of death could only be stated as hypovolaemic shock due to PPH.

Cross-Examination

[45] Dr. Daisley's evidence in my judgment was severely undermined in cross-examination by several concessions he was forced to make. A major concession was his admission that his conclusion that Karen's post-partum haemorrhage could have been due to a lacerated fornix and a ruptured uterus was based on an error, that error being that the laceration suffered by Mrs. Lezama was to the posterior fourchette which was an external injury rather than to the fornix which was within the cervix. In my judgment that concession and indeed many of his answers during cross-examination demonstrated how speculative his report was. Among them was his concession that proper management of AFE was not within his competence.

<u>Dr. Hemant Persad</u>

[46] Dr. Hemant Persad is an obstetrician and gynaecologist with extensive medical experience including twelve years of lecturing at the Eric Williams Medical Sciences Hospital (EWMSH).

[47] Dr. Persad, in his report, stated that it was not the practice in any health facility in Trinidad or the United Kingdom for blood or blood products to be kept on hand for every specific patient in case it might be required. Where there is a significant risk of haemorrhage, blood samples are taken on admission in either labour or planned/elective surgery, with the cross-matching done if indicated. According to Dr. Persad, current regulations in Trinidad and Tobago forbid the

storage of blood or blood products, which is restricted to the Blood Bank at Port of Spain General Hospital, EWMSH and San Fernando General Hospital, with the main facility being at Port of Spain. Blood and/or its products may be requested on the basis of availability and priority. These criteria are determined by the Blood Bank Unit and not the attending Physician/Surgeon/Obstetrician.

[48] He said that it is not standard practice in Trinidad and Tobago or the UK to have blood on hand for deliveries. He said that in Trinidad and Tobago there is a chronic shortage of blood and blood products. Products like platelets or cryoprecipitate are very difficult to procure and can almost never be procured in a timely fashion.

[49] Dr. Persad stated that Mrs. Lezama was not a *known bleeder* with a history of PPH, as her previous three pregnancies and deliveries, all done at Stanley's, show no evidence to substantiate this. He said that in the case of a bleeder, blood/blood products are kept in cases where it is anticipated that there will be severe haemorrhage. He said that haemorrhage during and after childbirth is an *"uncertain matter"*. *"You do not know from the beginning that it will or will not happen"*. He added that even though uncertain, it is not good practice to cater for blood products because *"it is not cost effective"*. He insisted that a person with diabetes is no more at risk of bleeding than anyone else.

[50] As to the haemorrhaging, Dr. Persad agreed that PPH due to uterine atony is the commonest form of maternal mortality globally. He explained that an atonic uterus is a uterus which fails to contract after the baby is delivered and the placenta is expelled. In the normal course after delivery the uterus thus free of the foetus, placenta and amniotic fluid would contract. According to Dr. Persad, *"In the case where it does not happen, the uterus initially contracts and then relaxes and in the relaxation period, that is where the uterus then gets filled with blood."* He added that there may be a risk of that before birth *"if the labour was actually quite prolonged or if labour was stimulated with drugs and the labour was prolonged."* During cross-examination, Dr. Persad agreed that the records stated

that Mrs. Lezama's bleeding was heavy. He was then asked by Mr. Marcus SC for his opinion on fifty (50) units of syntocinon being administered after delivery to stop the bleeding. He stated that where bleeding is significant, twenty to eighty units of syntocinon are infused. He said that one would want to arrest the flow of bleeding as quickly as possible and that this means that you administer *"much more"*. The judge seemed to rely on this exchange to conclude that Dr. Persad supported Dr. Singh-Bhola's view that insufficient syntocinon was used. In my judgment, it is unclear from his exchange with Mr. Marcus SC whether he felt that fifty units were insufficient. He offered no opinion as to the cause of the bleeding after the foetus had been delivered.

[51] Asked whether an autopsy or post-mortem would be a way of determining whether it was AFE which caused the PPH, Dr. Persad stated that an AFE diagnosis is made on *"clinical suspicion"* and that an autopsy may or may not confirm it.

<u>Dr. Rawle Jibodh</u>

[52] Dr. Jibodh is an obstetrician and gynaecologist who, at the time of the preparation of the report, worked in Canada, although he had also practised his specialty in Trinidad and Tobago. At the time of giving evidence, he was attached to the Scarborough Hospital, Toronto, Canada. Dr. Jibodh's evidence supported in the main Dr. Achong Low's evidence that AFE was the primary cause of Mrs. Lezama's death. He said that the appearance of non-clotting blood that occurred at Mrs. Lezama's delivery suggests clinically that a coagulation disorder was occurring. A laboratory investigation, if available, could have added to the diagnosis. He stated that the patient should have been infused with blood and blood products, platelets and cryoprecipitate. Surgical management, for example, hypogastric artery ligation, hysterectomy or uterine artery embolization, if done, could have reduced bleeding but would have been risky in the presence of a coagulopathy in such an unstable patient. If blood, fresh frozen plasma, platelets and cryoprecipitate had been given to the patient, the coagulation process might

have been reversed.

[53] Dr. Jibodh added that the diagnosis of AFE was a reasonable one due to the abrupt onset of hypotension, cardio respiratory failure and disseminated intravascular coagulation leading to her death. The patient experienced consumption coagulopathy, hemorrhage, a drastic fall in blood pressure and cardiac arrest, which led to her demise. This was consistent with the diagnosis of AFE. While an autopsy result could have added to the diagnosis, AFE is generally diagnosed clinically by identifying characteristic signs and symptoms (Dr. Jibodh cited Williams Obstetrics 25th edition at page 848). Dr. Jibodh described AFE as a rare event which could not have been anticipated. He added that there would have been no expectation of having blood available in the nursing home prior to the delivery. There is no data that any type of intervention would improve maternal prognosis with AFE. In Dr. Jibodh's opinion, in view of the emergency that arose at the delivery and the resources available, the appellant *"acted in the best interest of the patient."*

[54] In cross-examination by Mr. Marcus SC, he was asked what he would do if, after rubbing for four hours and after administering syntocinon, the bleeding did not stop. He responded, *"It depends on the condition of the patient, I would call someone whose (sic) senior to me, I will try and get the patient, if the patient is stable enough, I will try and transfer to a place where someone can help with further management."*

[55] He would not have considered surgery until *"everything"* had failed. He added that in this particular case it would have been dangerous to try removing the uterus. He would try to get help from as many people as he could, for example, a haematologist, anaesthetist or a gynaecologist and he would make calls to the blood bank to try to get blood.

[56] He added that, from the notes, he subscribed to the view that Mrs. Lezama suffered ultimately from AFE. He denied that that could only be conclusively

proved by an autopsy. He said that as to the symptoms - coldness, low blood pressure, pulse rate, the heart beat - *"They were consistent with shock and the sequence of events, and the time frame in which it happened; it's unique of amniotic fluid embolism"*. He went on to say that the *"Patient had the blood pressure dropped, she had cardiopulmonary failure and she had DIC. A blood clotting disorder, there are the cardinal symptoms."* He held to his view that the blood loss was small. He said that eighty-five percent (85%) of patients with AFE will die of cardiogenic shock. Asked by Mr. Marcus whether he would record AFE in recording the cause of death, he conceded that *"this was the reasonable thing to apply to the certificate, yes"*. He held to his view that Dr. Achong Low, *"in the circumstances of an emergency, ... was present to do the resuscitation. He did whatever he could and I can't see how this is coming about where he didn't do his best."*

Analysis and Conclusions

Medical definitions

[57] Before discussing the issues raised under this heading, it would be useful to define some of the medical terms relevant to this matter. As will be seen, that is easier said than done because it sometimes requires resort to other medical terms which are themselves highly esoteric to the medical profession. The following information is sourced from the expert evidence provided as well as the articles attached to the expert evidence.

[58] Dr. Rawle Jibodh, in his report, provided a definition of AFE from Williams Obstetrics 22nd edition pages 845 & 846. It is a complex disorder characterized by the abrupt onset of hypotension, hypoxia and consumptive coagulopathy. There is a great deal of individual variation in its clinical manifestation. In some women, one of these three clinical signs may dominate or be entirely absent. The syndrome is uncommon but it is a common cause of maternal death. In its classic manifestation, a woman in the late stages of labour

or immediately postpartum begins gasping for air and then rapidly suffers seizure or cardio respiratory arrest complicated by consumption coagulopathy, massive haemorrhage, and death. Dr. Jibodh quotes Williams Obstetrics 25th Edition at page 848: *"[T]here is no data that any type of intervention improves maternal prognosis with amniotic fluid embolism"*.

[59] Professor Daisley attached a list of references to his report for the purposes of giving a better understanding of the medical conditions discussed. AFE is defined as a rare and incompletely understood obstetric emergency. Amniotic fluid, fetal cells, hair or other debris enter the mother's blood stream via the placental bed of the uterus. This triggers an allergic reaction. This reaction then results in cardiorespiratory collapse and coagulopathy. Professor Daisley explains that in diseases known as coagulopathies, there is a bleeding disorder which stems from a failure of clotting. DIC is one such coagulopathy.

[60] In Professor Daisley's reference material, *"disseminated intravascular coagulation"* is described as a rare condition which may cause excessive clotting or bleeding throughout the body. It may lead to organ failure or death. The body's natural ability to regulate blood clotting does not function properly. The blood's clotting cells clump together and clog small blood vessels throughout the body. This causes damage to organs and destroys blood cells. The excessive clotting also depletes the supply of platelets and other clotting factors. The blood can no longer clot normally. The result is widespread bleeding both internally and externally. DIC can be hard to diagnose.

[61] According to Dr. Singh-Bhola, indeed all three gynaecologists, *"postpartum haemorrhaging"*, in the context of a vaginal delivery, is defined as the loss of greater than five hundred (500) mls of blood following delivery. She said that the most common cause of PPH is uterine atony. Uterine atony is defined as a soft, non-contracted uterus. Dr. Daisley provided a list of possible causes of PPH: uterine atony, trauma from the delivery, retention of tissue from the placenta or foetus and bleeding disorders (including DIC). Lastly, as the appellant

testified, AFE is one of a number of conditions that causes DIC and postpartum haemorrhage.

The judgment

[62] The judge committed three material errors. First he did not make any finding on whether the appellant's alleged diagnosis of AFE was reasonable in the circumstances and if so, whether his treatment of Mrs. Lezama in light of that diagnosis met the *Bolam* standard. Second, he ought not to have taken Dr. Manning-Alleyne's statement of Karen being a *bleeder* into account having already found that the documentary evidence did not support it. As to the third error the judge wrongly concluded that only fifty (50) units of syntocinon were given to Mrs. Lezama and that this was insufficient having regard to what was accepted as good practice. These errors are sufficiently material to warrant a re-examination of the evidence.

[63] As to the first error, while it is true that it cannot now be confirmed that AFE was the primary cause of death, what we are now concerned with is whether the appellant's treatment of Mrs. Lezama met the *Bolam* standard. The alleged diagnosis of AFE by the appellant would have affected how he dealt with the PPH and thus needed to be considered in order to decide whether his treatment met the *Bolam* standard. By failing to consider the reasonableness of the alleged diagnosis the judge failed to consider a major part of the appellant's case. An important part of that analysis however was a finding of fact as to whether Dr. Achong Low had made such a diagnosis at the time.

[64] As to the second error, the judge rightly found that the documentary history available to the appellant at the time would not have given him any forewarning that Mrs. Lezama was in fact a *bleeder*. Dr. Manning-Alleyne's statement at the time of delivery would not have taken the matter any further. The haemorrhage occurred just after delivery; the emergency had by then presented and the bleeding, by the appellant's own words, was significant. Urgent and

immediate action was already necessary.

[65] As to the third error, the judge wrongly concluded that only fifty (50) units of syntocinon were given to the patient as opposed to the recommended dosage of eighty (80) units. Dr. Singh-Bhola in her witness statement did testify that eighty (80) units of syntocinon in that situation was the practice in an emergency. Dr. Persad made a similar statement in cross-examination. But, as demonstrated by Mr. Benjamin, it appears from the nurse's notes that as much as ninety (90) units of syntocinon were given during the emergency. I agree that the evidence did not support the judge's finding.

[66] The errors of the judge, particularly on the issue of the appellant's alleged diagnosis of AFE, require that the Court of Appeal re-examine all of the evidence afresh and come to its own conclusion. I say at the outset of this analysis that the trial judge came to the right conclusions on all three heads of negligence and his analysis of the appellant's treatment of Mrs. Lezama, particularly as it relates to the failure to request and infuse blood and blood products, is largely correct. I however arrive at those conclusions for somewhat different reasons.

The cross-examination point

[67] At ground [xiii] of the grounds of appeal, the appellant contended that the judge failed to appreciate that Mr. Marcus SC did not put the suggestions of negligence or sub-standard care suggested by Dr. Singh-Bhola to the appellant and that he proceeded to make findings against the appellant even though these suggestions were not put to him. The general rule on the effect of a failure to cross-examine on a relevant issue emanates from the decision of the House of Lords in **Browne v. Dunn (1893) 6 R 67**. The report itself is somewhat obscure but the decision is quite clearly discussed in a passage by Hunt J in the Australian case of **Allied Pastoral Holdings Pty Ltd v Federal Commr of Taxation [1983] 1 NSWLR 1** (as cited by the English Court of Appeal in **Markem Corp and Anor. v. Zipher Ltd.; Markem Technologies Ltd and Ors. v Buckby and Ors.**

[2005] EWCA 267, **[2005] RPC 31** at paragraph 59).

[68] In **Browne v. Dunn**, Lord Herschell, L.C. stated (at pages 70 – 71) that it was absolutely essential to the proper conduct of a case, that where it is intended to suggest that a witness is not speaking the truth on a particular point, to direct his attention to the fact by some questions put in cross-examination showing that that imputation is intended to be made. Counsel should not let the evidence go unchallenged and then, when it is impossible for the witness to explain, argue that the witness is unworthy of credit. Lord Herschell added that he had always been of the understanding that if you intended to impeach a witness, you are bound, while he is in the box, to give him an opportunity to make any explanation which is open to him. He described it as essential to fair play and fair dealing with witnesses. He noted however, that there was no obligation to raise the matter in cross-examination where it is perfectly clear that the witness has had full notice beforehand that there is an intention to impeach the credibility of the story which he is telling. But the credibility of a witness should not be impeached on a matter on which he has not had any opportunity of giving an explanation by reason of there having been no suggestion during the course of the case that his story is not accepted.

[69] Lord Halsbury concurred (see pages 76 - 77). He expressed the view that it would be unjust not to cross-examine witnesses upon evidence which they have given so as to give them notice, an opportunity to explain and an opportunity to defend their characters, and then to ask the jury to disbelieve what the witness said. Lord Morris (pages 77 – 79) stated that he agreed with Lord Herschell and Lord Halsbury but he wished to guard himself with respect to laying down any hard-and-fast rules regarding cross-examining a witness as a necessary preliminary to impeaching his credit. Lord Bowen (pages 79 – 80) did not state any general principles on this subject.

[70] From the foregoing, it may be distilled that, as a general rule of fairness, counsel should cross-examine a witness with regard to any matter in which

counsel's case differs from the evidence put forward by the witness. The exception to the rule would seem to be where it is perfectly clear that the witness has had full notice beforehand that there is an intention to impeach the credibility of the story which he is telling (as per Lord Herschell at page 71) or where the witness' story is of *"an incredible and romancing character"* (see Lord Morris' judgment at page 79).

[71] Further exceptions to this rule have been expressed. Phipson on Evidence, Fourteenth Edition at paragraph 12-13 states that where several witnesses are called to the same point, it is not always necessary to cross-examine them all. The author notes however that it is safer for counsel to seek the judge's leave not to put the same points to witnesses who have repeated evidence already cross-examined to. It has been held, in a criminal matter, that where the overall tenor of cross-examination is designed to show that the witness' account is incapable of belief, it will not always be necessary to put to him explicitly that he is lying (**Lovelock [1997] Crim LR 821**). There may be cases where it is perfectly clear to the witness that his evidence is disputed or is inconsistent with evidence that has gone before, in which no injustice would be done by failure to cross-examine him (**Halsbury's Laws of England, Vol 28 (2015), para 531, Lovelock (as above), Wilkinson v DPP [2003] EWHC 865 (Admin), 167 JP 229, [2003] All R (D) 294 (Feb)**).

[72] **Browne v. Dunn** was applied in **Chen v. Ng [2017] UKPC 27**, **[2017] 5 LRC 462** in which Lord Neuberger and Lord Mance opined at paragraph 53:

> ***"Mr Parker relies on a general rule, namely that "it will not do to impeach the credibility of a witness upon a matter on which he has not had any opportunity of giving an explanation by reason of there having been no suggestion whatever in the course of the case that his story is not accepted", as Lord Herschell LC put it in Browne v Dunn (1893) 6 R 67, 71. In other words, where it is not made clear during (or before) a trial that the evidence, or a***

> ***significant aspect of the evidence, of a witness (especially if he is a party in the proceedings) is challenged as inaccurate, it is not appropriate, at least in the absence of further relevant facts, for the evidence then to be challenged in closing speeches or in the subsequent judgment. A relatively recent example of the application of this rule by the English Court of Appeal can be found in Markem Corpn v Zipher Ltd [2005] RPC 31."***

[73] Mr. Marcus' cross-examination did not infringe the general rule. It is evident from the cross-examination that the appellant's competence was being challenged. This is particularly so on the issue of whole blood only being given at 7:30 p.m. when Mrs. Lezama was described (by the appellant) as ninety-nine percent (99%) dead. Mr. Marcus SC also challenged the appellant on a number of fronts:

(i) His failure to order an autopsy and his truthfulness on that issue. This went to the question of whether he did in fact diagnose AFE.

(ii) Whether *whole blood* contains clotting factors and whether it contained fewer clotting factors if it is older blood (in storage for a long time). This went to the question of whether DIC was being properly treated.

(iii) Whether bleeding had in fact been controlled despite four hours of uterine massage.

(iv) Whether the appellant was wasting his time by rubbing the patient's abdomen (uterine massage) for four hours given that DIC was the cause of death.

[74] The overall tenor of the cross-examination was directed at impugning the competence of the appellant in the treatment of the patient and the appellant from his responses was under no illusion that his competence was not under attack. He would also have read the witness statements of Dr. Singh-Bhola and Professor Daisley as well as those of Dr. Manning-Alleyne and Dr. Chang.

The standard of care

[75] The judge rightly stated the relevant law to be the *Bolam* test, relying on Lord Browne-Wilkinson's authoritative dictum in **Bolitho v. City and Hackney Health Authority [1998] AC 232**, **239**:

> ***"The locus classicus of the test for the standard of care required of a doctor or any other person professing some skill or competence is the direction to the jury given by McNair J. in Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 583, 587:***
>
>> ***'I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.' "***

[76] Lord Brown-Wilkinson also added at page 239:

> ***"Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered: Bonnington Castings Ltd. v. Wardlaw [1956] A.C. 613; Wilsher v. Essex Area Health Authority [1988] A.C. 1074. In all cases the primary question is one of fact: did the wrongful act cause the injury?"***

[77] The question therefore is whether the appellant acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art and, secondly, whether a breach of duty of care was proved in this case. There is no doubting that the appellant owed such a duty of care to Mrs.

Lezama. It is an issue of fact however whether it was the appellant's wrongful act or omission which caused Mrs. Lezama's death. The onus lay on the respondent to prove it.

Did the appellant diagnose AFE?

[78] It seems to me that if AFE were his working diagnosis at the time of the emergency, it would have affected the appellant's treatment of the patient. The question is whether it was reasonable in the circumstances for the appellant to have made such a diagnosis, if in fact he did make it. Reasonableness is to be judged against the *Bolam* standard, that is to say, whether such a diagnosis would have been accepted as proper by a responsible body of medical men skilled in that particular field. In the cross-examination of Drs. Singh-Bhola and Jibodh, it emerged that a significant number of the symptoms of AFE presented in Mrs. Lezama. In those circumstances, and in agreement with both Dr. Singh-Bhola and Dr. Jibodh, it would have been reasonable for the appellant to have diagnosed AFE. In this regard I agree with Dr. Jibodh's evidence given in cross-examination that it would also have been reasonable to put AFE on the certificate as a cause of death.

[79] But the evidence of Mr. Lezama as well as the appellant's entry of the cause of death in the death registration certificate as PPH, DIC and still birth, without any reference to AFE, raised doubt as to whether the appellant did in fact diagnose AFE at the time of the emergency. (This is so irrespective of whether or not his failure amounted to a previous inconsistent statement) Indeed he was challenged on this issue of fact by Mr. Marcus SC in cross-examination. Having reviewed the witness statements, exhibits and transcripts of the trial, I do not accept the appellant's contention that, during the haemorrhaging, he diagnosed Mrs. Lezama's condition as AFE. It is my judgment that this is a conclusion to which he came after sober reflection. The appellant's explanation at paragraph 28 of his witness statement (reproduced at paragraph 24 above) as to why he did not put AFE on the death registration entry is unpersuasive. He does not say at

paragraph 28 that AFE was the definite cause, but that DIC is *"one of the conditions"* which can occur with an amniotic fluid embolism. In cross-examination he was challenged by Mr. Marcus SC as to why he did not put AFE as the cause of death. These were his answers:

> ***"A Okay. I made a presumptive diagnosis of AFE, but because I am writing as official document, right, and I am not a presumptuous person, that I am going to write a presumptive diagnosis as cause of death, right. I wrote the things that were open and objective, for everybody to see but both diagnoses lead back and tie back if one were to see my note, or discuss with me, as to what may have been the cause of the delays [death?]. So, DIC, and the fact that there was a stillbirth, in my mind these things were objective things that I could write. I cannot write, in my mind, certainly I couldn't write on a death certificate, something that was a presumptive diagnosis …***
>
> ***A … I wrote postpartum haemorrhage, but not as a direct cause of death. You know, there is a heading, if you refer to the form, you will see very -- it says other causes that, may be present but not contributory. And that's where the postpartum haemorrhage comes in because as one can see I'm writing what was objective.***
>
> ***Q At least one thing we know is that there was room for you to have put AFE, if you wanted to?***
>
> ***A If I wanted, I guess I could have written anything."***

[80] The allegation of a presumptive diagnosis was quite a retreat from his confident diagnosis of AFE at paragraph 17 of his witness statement. Moreover, as I have noted at paragraph 79, given that some of the symptoms of AFE were conceded by Dr. Singh-Bhola and accepted by Dr. Jibodh as having presented, it would have been reasonable, as Dr. Jibodh said, to have written AFE in the death registration entry.

[81] Moreover, while the appellant did obtain *whole blood* to treat what he stated to be DIC secondary to AFE, the continued rubbing of the patient's stomach for four hours suggested that the working diagnosis was PPH caused by an atonic uterus rather than AFE. Dr. Singh-Bhola's evidence supports this conclusion. So too does Dr. Chang's who deposed that when he got to Stanley's the working diagnosis was PPH. The appellant's evidence in cross-examination that he was rubbing *"prophylactically"* was unpersuasive. The appellant contended that he sought Mr. Lezama's permission to do an autopsy and he refused. This was strongly denied by Mr. Lezama. Dr. Manning-Alleyne also stated that given the manner of death, she told him that this was a *"coroner's case"*, meaning that an autopsy was necessary (in spite of the family's wishes). He also denied that this was told to him. In so far as I am to make that finding of fact, I accept the evidence of Mr. Lezama and Dr. Manning-Alleyne that Dr. Achong Low refused to request an autopsy. This finding also affected his credibility.

[82] Dr. Chang's evidence that the *"working diagnosis was post-partum haemorrhage ..."* suggests that no mention of AFE as an underlying factor arose during the emergency. Surely if such a factor were operative in Dr. Achong Low's mind it would have been made known to Dr. Chang given his critical role in the emergency.

Did the appellant's treatment meet the Bolam standard?

[83] The burden of proof that the appellant was negligent and that his

negligence caused the death of Mrs. Lezama was on the respondent. That burden is on a balance of probability. Michael A. Jones in his book Medical Negligence, Fifth Edition at page 361 paragraph 3 – 177 submits that *"This standard tends to conceal the fact that the cogency of the evidence that the courts require in order to satisfy the test can vary with the issues at stake."* In the case of **In re D (Secretary of State for Northern Ireland intervening) [2008] UKHL 33; [2008] 1 WLR 1499**, Lord Carswell considered this question of the apparent flexibility of the civil standard of proof. At paragraph 27 he said:

> ***"27. Richards LJ expressed the proposition neatly in R (N) v Mental Health Review Tribunal (Northern Region) [2005] EWCA Civ 1605, [2006] QB 468, 497-8, para 62, where he said:***
>
>> ***'62. Although there is a single civil standard of proof on the balance of probabilities, it is flexible in its application. In particular, the more serious the allegation or the more serious the consequences if the allegation is proved, the stronger must be the evidence before a court will find the allegation proved on the balance of probabilities. Thus the flexibility of the standard lies not in any adjustment to the degree of probability required for an allegation to be proved (such that a more serious allegation has to be proved to a higher degree of probability), but in the strength or quality of the evidence that will in practice be required for an allegation to be proved on the balance of probabilities."***
>>
>> ***In my opinion this paragraph effectively states in concise terms the proper state of the law on this topic. I would add one small qualification, which may be no more than an explanation of what Richards LJ meant***

about the seriousness of the consequences. That factor is relevant to the likelihood or unlikelihood of the allegation being unfounded, as I explain below.

28. It is recognised by these statements that a possible source of confusion is the failure to bear in mind with sufficient clarity the fact that in some contexts a court or tribunal has to look at the facts more critically or more anxiously than in others before it can be satisfied to the requisite standard. The standard itself is, however, finite and unvarying. Situations which make such heightened examination necessary may be the inherent unlikelihood of the occurrence taking place (Lord Hoffmann's example of the animal seen in Regent's Park), the seriousness of the allegation to be proved or, in some cases, the consequences which could follow from acceptance of proof of the relevant fact. The seriousness of the allegation requires no elaboration: a tribunal of fact will look closely into the facts grounding an allegation of fraud before accepting that it has been established. The seriousness of consequences is another facet of the same proposition: if it is alleged that a bank manager has committed a minor peculation, that could entail very serious consequences for his career, so making it the less likely that he would risk doing such a thing. These are all matters of ordinary experience, requiring the application of good sense on the part of those who have to decide such issues. They do not require a different standard of proof or a specially cogent standard of evidence, merely appropriately careful consideration by the tribunal before it is

satisfied of the matter which has to be established.' "

[84] There is nothing in the facts of this case which requires any heightened examination of the kind stated by Lord Carswell. Certainly there are consequences to the appellant's reputation if the finding of the judge is upheld. But even if there are, I have given careful consideration to the whole of the evidence. I note as well that the consequences to Mrs. Lezama's family were immeasurable.

[85] The trial judge found that more than sufficient time had elapsed from the commencement of bleeding (at delivery) and 7:30 p.m. (when blood was transfused) during which time steps ought to have been taken to source and administer blood and blood products. The appellant, he said, should have requested blood at an earlier stage and the evidence of the witnesses for both parties supported this. For this reason he held that the appellant had failed to take urgent and immediate or any steps to stop the haemorrhage once it had started.

[86] I agree. The evidence of all the experts in this case was that there was a need for urgent and immediate infusion of blood into the patient. The appellant stated that it was evident that there was a coagulation problem. This assessment was made almost immediately after the haemorrhaging began at 4:53 p.m. but he did not decide to take blood for cross-matching until 6:40 p.m., almost two hours after the bleeding started. Blood was not infused until 7:30 p.m. by which time it appeared that Mrs. Lezama was already clinically dead. Dr. Singh-Bhola, who even on the printed evidence was an impressive witness, stated that if the source of the bleeding is a coagulation disorder then replacement of the blood and clotting factors is essential. Dr. Jibodh in his witness statement stated that while the appellant administered supplemental oxygen, monitored oxygen saturation, performed uterine fundal massage and intravenously infused oxytocin, crystalloids, blood and haemaccel in an attempt to support circulation, he needed to administer more blood plus blood products. Dr. Jibodh did acknowledge that these may not have been available.

[87] It is correct that the prompt availability of blood and blood products was in question but, as the judge rightly noted, a request should have been made much earlier than it was. The judge accepted the untested evidence of Dr. Waveney Charles in her witness statement that blood was available, in emergency cases, from the blood bank. It was open to him to do so and in any event, I agree. Counsel for the appellant challenged this but I cannot fault the judge's finding. We are concerned with the quality of care given to Mrs. Lezama and whether it met the *Bolam* standard. The appellant ought to have made his request from the blood bank much earlier. If having made that early request for blood there was delay in its arrival, then appropriate evidence of the delay could then have been led. In my judgment such a request should have been made immediately upon the manifestation of the haemorrhage at 4:53 p.m. In any event, Dr. Achong Low stated that because of his relationship with the St. Clair Medical Centre, he was able to obtain blood from that facility for the patient. It suggests then that it was always open to him to request blood from this facility and that he thus had no difficulty in obtaining blood for Mrs. Lezama.

[88] Further, the hydration of the patient was inadequate. Dr. Singh-Bhola stated in her witness statement that the appellant's *"resuscitation effort was inadequate. Only three units of fluid were given during the first two hours after delivery".* She added that the fact that the patient remained cold, clammy, tachycardic, hypotensive and had little urine output would indicate that fluid replacement was inadequate. Even though seven units of colloids (haemaccel) were eventually given, this was after the first two hours. This was supported by Dr. Chang in his witness statement at paragraph 6:

> ***There were no haemoglobin tests done. The patient had been given three litres of fluid between the hours of 5:15 p.m. and 7:25 p.m. and the urine output was only 20 ml. This informs me that the intravenous resuscitation effort was not adequate and the patient was not adequately hydrated. If a patient is adequately***

hydrated the urine output would be at least ½ ml per kilogram per hour i.e. 35 mls/hour for a 70 Kg adult.

[89] Dr. Singh-Bhola also suggested that the fluids were infused too slowly. The following passage in cross-examination is of assistance:

> ***"A: … yes she was given Haemaccel, but the point I was making is that it wasn't given as quickly as it should have been given.***
>
> ***Q: But it can't be "as quickly as it should have been given", because as soon as she went into shock, she was given it.***
>
> ***A: Yes.***
>
> ***Q: You are assuming that the first bag of Haemaccel expired -- finished, and it took a while before the second one was administered? Is that what you're assuming when you made that comment?***
>
> ***A: Well, I'm not making an assumption. What I'm saying is that based on what's documented, the second litre of Haemaccel was not commenced until 6:40.***
>
> ***Q: Correct, but you are assuming that there is a lapse in time between the first finishing, and the second being given?***
>
> ***A: Or it could have been that the first was given very slowly. So, even though the second was started immediately after, the first was given not quickly enough.***
>
> ***Q: And this is an assessment you're making from looking at the notes, and you're telling us that the way to apply it -- before, you gave us evidence -- the way to apply it quicker, would be to use a bigger needle - a larger needle, if I may call***

it that - or more pressure on getting the fluid in. Correct?

A: That's right. In other words, in an emergency situation when one's blood pressure is low, we would sometimes squeeze the Haemaccel, to allow it to infuse very quickly, over minutes – –– ten, 15 minutes, sometimes.

Q: Understood. But there is absolutely nothing here, suggesting that that wasn't done. Is there?

A: No, there is nothing suggesting it wasn't. But if it was, it wouldn't take an hour and a half to go through.

Q: You do not think it would take an hour and a half to have gone through?

A: If it's being squeezed? No, it shouldn't take that long."

[90] In addition, and in agreement with the trial judge, the appellant failed to call for help in a timely manner. The evidence of Dr. Singh-Bhola supported this conclusion. She stated that despite the fact that an anaesthetist would have been invaluable in helping with resuscitation, maintaining the patient's airway and inserting lines, he was not called until two and a half hours after delivery. That he was in need of help was unwittingly admitted to by the appellant when he was re-examined by Mr. Young. He was asked by Mr. Young why blood was only administered at 7:30 p.m. This was his answer:

"Q Can you just tell us?

A All right first of all, first of all at 5:15 when the patient basically went into shock, my first reaction is that I had to, especially with the prior knowledge when I had seen the blood wasn't clotting, and I had already formulated that presumptive diagnosis. I knew I had to get as much fluid into this patient as

possible. She had one IV line and we had to get up another IV line and then in terms of the any sort of blood, blood products that we sent for we had to cross match the patient. So that means I had to take a vial of blood to send. In that kind of situation essentially, it did take and it takes sometimes a long time to insert an IV line and in terms of getting a specimen of blood and it may have taken twenty minutes thirty minutes even. When that line was in, we have to work on getting as much fluid and blood substitute into that patient as possible.

So that the Haemaccel and the ringer's lactate and basically I had to, you know Stanley is no -- this is a Sunday night and normally, normally there is no huge amount of help in terms of physician help around. There was one physician present, but that is Dr. Manning, and basically Dr. Manning did not do very much. Basically in my mind I would tell you, while I was doing all of these things, I was sort of wondering why was Dr. Manning not moving and helping me …

[91] It is apparent from that passage that Dr. Achong Low was in need of help from another specialist, in this case, as Drs. Singh-Bhola and Jibodh testified, at least an anaesthetist. Dr. Manning-Alleyne candidly admitted that she was a paediatrician and not trained for that type of emergency. She helped where she could. No doubt it was because of this that she suggested Dr. Kuruvilla and Dr. Chang. The appellant did eventually answer that Stanley's did not have any supply of blood, nor any laboratory for testing and cross-matching of blood. In so far as he sought to blame inadequate facilities at Stanley's, it did not assist his case. The appellant well knew the limitations of the facility at which he practised.

Secondly it was open to him to join the owner/operator if he felt that this contributed to the death of Mrs. Lezama.

[92] Further, Dr. Chang was requested by Dr. Manning-Alleyne rather than the appellant. She had also requested the assistance of Dr. Ajit Kuruvilla. Dr. Kuruvilla did come to the delivery room but the appellant told him that he did not need any help. Dr. Kuruvilla's enquiry was certainly much earlier than Dr. Chang's. The evidence is that by the time Dr. Chang arrived Mrs. Lezama was already virtually dead. Indeed, Mr. Lezama quoted Dr. Chang as telling the family, during the brief conference they had with the doctors when it was contemplated that Mrs. Lezama might be transferred to another facility, that he had only come as a favour to Dr. Manning-Alleyne and on arrival he saw a *"flat line"* on the monitor. That latter statement is supported by Dr. Chang in his witness statement where he said that on his arrival at the delivery room the patient *"was comatose and had a cardiac arrest"* An earlier request would certainly have given Mrs. Lezama a greater chance of survival. Dr. Chang did succeed however in getting some kind of cardiac response before Mrs. Lezama arrested again. Dr. Chang's account as to the improper hydration of the patient is generally consistent with Dr. Manning-Alleyne's eyewitness account of a lack of urgency particularly in the infusion of haemaccel (or volume expanders) by the appellant. It is clear from the accounts given by Mr. Lezama, Dr. Manning-Alleyne and even Dr. Achong Low himself that he was overwhelmed by the sudden and massive PPH. Even so he refused the help of Dr. Ajit Kuruvilla. Dr. Chang's arrival was in response to a personal appeal by Dr. Manning-Alleyne.

[93] More importantly, these findings belie the appellant's contention that he diagnosed AFE. His alleged diagnosis of AFE was made quite soon after the haemorrhaging began yet no effort was made to obtain blood for Mrs. Lezama until 6:40 p.m. at earliest. In cross-examination he was challenged by Mr. Marcus SC as to why, if he was treating the patient for DIC secondary to AFE, he waited until 7:30 p.m. to administer *whole blood*. His answer in effect was that blood was difficult to obtain. If in fact he had made such a diagnosis then his failure to

move with alacrity to obtain blood and to call for assistance is even more compelling of negligence. The appellant alleged that he had five previous cases of AFE and had been successful in saving four of those patients. If that is true then he ought to have had more than a fair knowledge of how to successfully deal with such a condition. I thus find in the alternative that, even if the appellant did diagnose AFE, he was still negligent for the reasons stated above.

[94] The trial judge found that the appellant failed to administer sufficient dosages of syntocinon to stop the bleeding. I have already stated that the evidence does not support this finding. But Dr. Chang's unchallenged evidence is that sufficient fluids were not given between 5:15 p.m. and 7:30 p.m. when he arrived. Dr. Singh-Bhola's evidence on this issue supports him. I have set it out at paragraph 36. The insufficient infusion of volume expanders (haemaccel) supports the judge's finding of failure to administer sufficient medication to stop the bleeding. In any event, it is sufficient to support a finding of failure to exercise due care and diligence in the treatment of the deceased in all the circumstances of the case.

[95] The judge also found that the fact that there was only one intravenous access in operation (in addition to the appellant's failure to call for help earlier) meant that the appellant was negligent by failing to exercise all due care and diligence in the treatment of the deceased in all the circumstances of the case. The ruling is also supported by Dr. Chang's evidence. His evidence is a direct eye-witness account of the type of medical attention Mrs. Lezama received at the hands of the appellant. Use of only one intravenous access surely contributed to the lack of hydration of the patient of which Dr. Chang complained. There was sufficient evidence to support the judge's finding on this ground.

[96] The appellant also challenged the reliance that the judge placed on Dr. Daisley's evidence. I agree that Dr. Daisley's evidence was undermined in cross-examination and was shown to be speculative. The judge ought not to have relied on it. But his reliance was not fatal to his conclusion. He found that PPH was the

cause of death but made no finding as to the cause of the PPH. Much of Dr. Daisley's evidence went to discrediting AFE as the cause of death and to suggest that there were other possible causes which may have triggered PPH.

[97] The appellant also sought to discredit Dr. Manning-Alleyne's evidence as being inaccurate and untrustworthy. I do not agree. Dr. Manning-Alleyne insisted during cross-examination that no volume expanders (haemaccel) were given and that no blood was taken for cross-matching while she was in the delivery room. As it turned out haemaccel was given at 5:15 p.m. and a sample of blood was taken at 6:40 p.m. This did not impact on her credibility. Dr. Manning-Alleyne was not always in the delivery room and might have missed when these procedures were done. For the same reason and no doubt because of the frenetic nature of the emergency, the times she gave for certain events occurring did not gel with the notes taken by the nurses. But her general perception of inaction and insufficiency of fluid hydration was supported by Dr. Chang. It is also consistent with Dr. Singh-Bhola's opinion. Dr. Singh-Bhola, even though by far the most inexperienced of the three obstetricians/gynaecologists, gave compelling evidence. But in any event, in so far as the treatment of AFE is concerned, there was little between them since only Dr. Jibodh had encountered such a case and he did not give details.

Conclusion

[98] In conclusion I find, having regard to all of the evidence and on a preponderance of probability, as follows:

(i) The appellant did not diagnose AFE as the cause of the DIC and PPH at the time of the emergency. His conclusion was more likely arrived at upon reflection after Mrs. Lezama's death. Further, his treatment of the patient, particularly four hours of uterine massage and the very late decision to infuse blood, did not suggest any such diagnosis.

(ii) The more likely cause of Mrs. Lezama's death, as deposed, was massive PPH brought about by uterine atony leading to DIC and ultimately death. Dr. Achong Low's original endorsement on the death certificate and his continued application of uterine massage for four hours also support this view. His attempts to explain away the death registration entries were unpersuasive. The fact that there was a massive haemorrhage is borne out by Mr. Lezama's account set out in his witness statement (at paragraphs 17, 19 and 20) that upon removal of the placenta *"a gush of blood and fluid gushed out covering all in its path"*, that *"Karen was bleeding profusely"*, that a pan used to catch the fluids drained from the delivery table *"was overflowing into a river of blood on either side of the table"* and that *"the river of blood reached at least 3 to 4 feet in either direction from the delivery table"*. My own suspicion is that the volume of blood lost by Mrs. Lezama is a lot more than the appellant was willing to admit. I accept the evidence of Dr. Singh-Bhola set out at paragraphs 37 and 38 above. Further, for the reasons set out at paragraphs 83 to 97, I agree with Dr. Singh-Bhola that once PPH occurred, it was not managed to a standard accepted as proper by a body of medical practitioners skilled in the field of obstetrics and gynaecology and it was this that caused Mrs. Lezama's demise.

(iii) But, in the event that I am wrong that Dr. Achong Low did not diagnose AFE and he did diagnose AFE, I say that for the same reasons, his treatment of the patient still fell below the *Bolam* standard. That negligent treatment, on a balance of probabilities, was the cause of the demise of Mrs. Lezama and the appellant is liable in damages.

<u>The counter notice on costs</u>

[99] I turn to the respondent's counter notice on costs. The respondent challenged the judge's order that the appellant pay the respondent's costs on the prescribed scale. Mr. Marcus SC submitted that the judge should have ordered that costs be assessed, or alternatively, he should have invoked Part 67.12(3) and

carried out the assessment himself at the hearing. He submitted that an order for assessed costs permits the party in whose favour the order for costs has been made, to file a bill showing the sum claimed and how it has been calculated. He further submitted that this would allow for relevant matters such as the length of the trial and its complexity to be taken into account.

[100] Rule 67.3 of the Civil Proceedings Rules 1998 as amended (the CPR) provides:

> ***Ways in which costs are to be quantified***
> ***67.3 Costs of proceedings under these Rules are to be quantified as follows:***
>
> ***(a) where rule 67.4 applies, in accordance with the provisions of that rule; and***
>
> ***(b) in all other cases if, having regard to rule 66.6, the court orders a party to pay all or any part of the costs of another party, in one of the following ways:***
>
> > ***(i) costs determined in accordance with rule 67.5 ("prescribed costs");***
> >
> > ***(ii) costs in accordance with a budget approved by the court under rule 67.8 ("budgeted costs"); or***
> >
> > ***(iii) where neither prescribed nor budgeted costs are applicable, by assessment in accordance with rules 67.1 and 67.12.***

[101] The respondent accepts that fixed costs under rule 67.4 and budgeted costs do not apply. This leaves to be considered prescribed costs and assessed costs. Rule 67.5 deals with prescribed costs. The relevant parts of rule 67.5 provide as

follows:

> ***(1) The general rule is that where rule 67.4 does not apply and a party is entitled to the costs of any proceedings those costs must be determined in accordance with Appendices B and C to this Part and paragraphs (2)–(4) of this rule.***
>
> ***(2) In determining such costs the "value" of the claim shall be decided -***
>
> ***(a) in the case of a claimant, by the amount agreed or ordered to be paid;***
>
> ***(b) in the case of a defendant –***
>
> ***(i) …***
>
> ***(ii) …***
>
> ***(iii) if the claim is not for a monetary sum, as if it were a claim for $50,000.00.***
>
> ***(3) The general rule is that the amount of costs to be paid is to be calculated in accordance with the percentage specified in column 2 of Appendix B against the appropriate value.***
>
> ***(4) …***

[102] Mr. Marcus SC submitted that the value of the death of the deceased does not arise and these provisions are therefore inapplicable to this case. He submits that rule 67.12 is applicable and the costs should be assessed. He relied on **Nizam Mohammed v. The Attorney General of Trinidad of Tobago**, **Civil Appeal No. 75 of 2013** and **Mukesh Maharaj v. The Attorney General of Trinidad of Tobago**, **Civil Appeal No. 118 of 2010**, **No. 67 of 2011**.

[103] Rule 67.12(1) provides as follows:

> ***"Assessment of costs—general***
>
> ***67.12 (1) This rule applies where costs fall to be assessed in***

relation to any matter or proceedings, or part of a matter or proceedings other than a procedural application."

Costs which fall to be *"assessed"* under rule 67.12 are costs in respect of proceedings for administrative orders under rule 56. Rule 56.14(5) provides for the judge to assess any order as to costs which he may make in respect of an application for an administrative order.

[104] The two decisions of this court in **Nizam Mohammed v. The Attorney General of Trinidad of Tobago, Civil Appeal No. 75 of 2013** and **Mukesh Maharaj v. The Attorney General of Trinidad of Tobago, Civil Appeal No. 118 of 2010**, **No. 67 of 2011** were decisions on the assessment of damages in applications for administrative orders. Rule 56.14(5) specifically provides for the costs of such applications to be assessed. *"Assessed"* as set out in rule 56.14(5) was held by Mendonça JA in **Nizam Mohammed** (at paragraph 10) to mean *"an assessment of the work done and a determination of the value of that work"* in respect of the application for an administrative order.

[105] In this case, the claim was founded in negligence. It is not an application for an administrative order so rule 67.12 does not apply. Since fixed costs also do not apply and no application for budgeted costs was made, the costs fell to be prescribed pursuant to rule 67.5. The judge was therefore right to order that costs be on the prescribed scale. Mr. Marcus SC's submission that the value of the death of Mrs. Lezama does not arise is not accurate. The parties in this case agreed that the assessment of damages, in which the amount (or value) of the claim would be decided, should be heard at a later date and that the matter would proceed only on liability. It meant that the costs of the trial would be determined when the damages were quantified. In this case the damages (and the value of the claim) were to be determined by a master in chambers. When that quantum is assessed by the master, she would then be required to make the appropriate order as to costs. It is for this reason that the judge ordered that the costs be quantified by the master. I can find no fault with that because he could not then have

determined the value of the claim.

[106] Mr. Marcus SC submitted that an assessment under part 67.12 allows for very relevant matters such as the length of the trial and its complexity to be taken into account. In my judgment if those were the concerns of counsel then he should have made any application for budgeted costs under Part 67.8.

[107] The appeal as well as the counter notice/cross appeal on costs is dismissed.

[108] We will hear the parties on the costs of the appeal and on the counter notice.

Nolan P.G. Bereaux
Justice of Appeal

I agree with the judgment of Bereaux J.A. and I have nothing to add.

R. Narine
Justice of Appeal

I too agree.

M. Mohammed
Justice of Appeal